



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LINDEN DILLIN MD
900 12TH STREET
FORT WORTH TX 76104

Respondent Name

WAL MART ASSOCIATES INC

Carrier's Austin Representative

Box Number 53

MFDR Tracking Number

M4-10-2999-01

MFDR Date Received

February 26, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance company, ARCMI, has processed CPT 29825 correctly. However, CPT 29819 has processed incorrectly. On this cpt they have paid 183.51 only. Per CCI Edits this code is valued at 799.90. I have submitted a letter of reconsideration with this information to the insurance & they have not paid any additional amount on this code."

Amount in Dispute: \$750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 29819 reimbursed as primary procedure in accordance with highest MAR value (\$1005.34) with net payment per RockPort PPO \$675.00 as directly applied by RockPort. (This conflicts with provider correspondence indicating payment of \$183.51 for this charge.) Note: Reimbursement limited to provider's billed charge \$750.00 in accordance with TDI/DWC RULE 134.202 (d) (1, 2 & 3) which states reimbursement shall be the LEAST of MAR, provider's U&C charge, or negotiated or contracted amount. CPT 29825 reimbursed as secondary procedure with MAR of \$1004.05 & CMS/NCCI multiple procedure status of '3' (multiple endoscopic procedures.) MAR \$1004.05 minus MAR for based code in same family (29805 \$800.15) = \$203.90. Net payment per RockPort PPO \$183.51 as directly applied by RockPort. TOTAL ALLOWANCE FOR BILL \$953.90 – NET PPO PAYMENT \$858.51."

Response Submitted by: Claims Management, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2009	29819	\$750.00	\$75.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 45 – Charges exceed your contracted/legislated fee arrangement
- 8 – The procedure code is inconsistent with the provider type/specialty
- 193 – Original payment decision is being maintained. This claim was processed properly the first time

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor bill for endoscopic procedures on December 1, 2009?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "45 – Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 22, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules." The requestor seeks reimbursement for CPT code 29819 defined by the AMA CPT Code Book as "Arthroscopy, shoulder, surgical; with removal of loose body or foreign body."

Per CMS "Special rules for multiple endoscopy procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure of each code with this indicator is identified in the Endobase field of this file. Apply the multiple endoscopy rules to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy."

The requestor seeks additional reimbursement for CPT 29819 in the amount of \$750.00 rendered on December 1, 2009. Reimbursement will be determined per 28 Texas Administrative Code § 134.203.

3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

The MAR amount for CPT code 29825 is \$1,004.05 and the MAR amount for CPT code 29819 is \$1,005.34, therefore CPT code 29819 is reimbursed at 100% of the MAR.

Review of the EOB's submitted with the DWC-60 supports that the insurance carrier issued payment in the amount of \$675.00 on December 20, 2009. The MAR reimbursement for CPT code 29819 is \$1,005.34.

Review of the CMS-1500 documents that the provider's usual and customary charge for CPT code 29819 is \$750.00. The difference between the insurance carrier payment of \$675.00 and the provider's usual and customary charge of \$750.00 is \$75.00, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$75.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$75.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	October 24, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.